STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	ILTIPLE CO	ONSTRUCTION	(X3) DATE COMPL		
AND FLAN	OF CORRECTION	155019	A. BUIL		00	07/19/	
NAME OF F	DOLUBER OR GURRU IE		B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIE				CURRY PK		
GARDEN	I VILLA - BLOOMII	NGTON		BLOOM	MINGTON, IN 47403		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F000000							
	This visit was State Licensu	for a Recertification and re Survey.	F000	0000			
	Survey dates : July 15, 16, 17	: 7, 18, & 19, 2013					
	Facility number Provider number						
	AIM number:						
	Survey team:						
	Cheryl Mabry, Kimberly Perig						
	Diana McDona	-					
	Melissa Gillis,	-					
	Denise Schwa	indner, RN					
	Census bed ty	/pe:					
	SNF/NF: 165 Total: 180						
	10tai. 100						
	Census payor	type:					
	Medicare: 20						
	Medicaid: 122 Other: 38	2					
	Total: 180						
		ncies reflect state in accordance with 410					
	Quality review cor	npleted on July 30, 2013, by					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155019	A. BUILDING B. WING	00	COMPLETED 07/19/2013			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
	I VILLA - BLOOMIN		1100 S CURRY PK BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
1710	Jodi Meyer, RN	200 IDENTIFICATIONATION	1710	•	DATE			
	,							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DEFE11

Facility ID: 000007

If continuation sheet Page 2 of 22

STATEMEN	T OF DEFICIENCIES	FICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE		JLTIPLE CC	ONSTRUCTION (X3) DATE S		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155019	A. BUII			07/19/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
0.4.00.51		OTON			CURRY PK		
GARDEN	I VILLA - BLOOMIN	GION		BLOOM	MINGTON, IN 47403		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F000282 SS=D	CARE PLAN The services prov facility must be pr persons in accord written plan of car Based on record		F00	0282	It is the policy of Garden Villa provide services by qualified		08/18/2013
	weekly blood p in the resident's for 1 of 40 resident	ressures as indicated s written plan of care dents reviewed for care tation. (Resident			persons in accordance with ear resident's written plan of care. Garden Villa submits the follow action as evidence of its commitment to compliance wit regulatory requirements. I. Wit corrective action(s) will be accomplished for those reside	ving h nat	
		e: s clinical records were ly 18, 2013 at 10:11			found to have been affected by the deficient practice? Reside #131 has had the care plan updated to reflect current care needs and monitoring. Previou this order had been discontinu	/ nt isly	
	but were not lind bipolar disorder chronic pain, do hypertension, a insufficiency.	and chronic renal			but was not removed from the plan of care, this has been corrected. II. How other residents having the potential be affected by the same defici- practice will be identified and what corrective action(s) will b taken? All residents have the potential to be affected. All	to ent e	
	January 21, 20 "Resident's b within normal li weekly monitor	lood pressure will stay mits as evidenced by ingMonitor B/P e] weekly. Report			care plans have been reviewed ensure that current needs are the plan and non-needed items removed. III. What measure will be put into place or what systemic changes will be made ensure the deficient practice do not recur? Care plans will be reviewed with each update to staff assignment sheets and update to staff assignment sheets and update to the staff assignment	on s es e to oes	

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Event ID: DEFE11

Facility ID: 000007

If continuation sheet Page 3 of 22

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	ETED
		155019	B. WIN			07/19/2	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L.					
CADDEN	IVIII A DIOOMIN	ICTON			CURRY PK		
GARDEN	I VILLA - BLOOMIN	IGTON		BLOON	IINGTON, IN 47403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	Interview with I 2013 at 3:25 p. blood pressure monthly vitals from blood press residents on with monitoring, the documented or Administration Vital Signs and indicated Resident Resident Administration Medication Administration Administration Administration Medicated Resident Was resident #131 monitored week care plan. Cor July 19, 2013 with Resident #131 monitored week care plan. Cor July 19, 2013 with Resident #131 monitored week care plan.	PN #13 on July 19, .m., indicated monthly is are recorded on the form for residents not ure medication. For eekly blood pressure blood pressure is in the Medication Record. I weight record dent #131's blood ecorded monthly April		TAG	any change in condition. At the least, will be reviewed monthly during change over to ensure to care plan reflects the current resident needs. IV. How corrective action(s) will be monitored to ensure the deficie practice will not recur? Weekly audits of the care plans will be conducted by nursing administration or designee to verify all interventions reflect the reside current condition. 100% of all resident new orders will be audited. This audit will be conducted weekly for 3 months and results reviewed in Quality Assurance. At 3 months, Qual Assurance will review previous audit results to determine if the audits can be reduced to monthly. Quality Assurance wibe looking for at least 95% compliant to reduce to monthly not meeting the benchmark weekly audits will continue. V. August 18, 2013	e y that ent of the second of	DATE

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Event ID: DEFE11

Facility ID: 000007

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155019	B. WIN			07/19/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CURRY PK		
CADDEN	I VILLA - BLOOMIN	CTON			IINGTON, IN 47403		
GANDLIV	I VILLA - BLOOMIN	GION		BLOON	111101011, 111 47403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000356	483.30(e)						
SS=C	POSTED NURSE	STAFFING					
	INFORMATION						
	The facility must p						
	information on a	daily basis:					
	o Facility name.	_					
	o The current dat						
		er and the actual hours lowing categories of					
		censed nursing staff directly					
		sident care per shift:					
	- Registered r						
	_	actical nurses or licensed					
		s (as defined under State					
	law).						
	- Certified nur	se aides.					
	o Resident censu	S.					
	The facility must	post the nurse staffing data					
	-	on a daily basis at the					
		n shift. Data must be					
	posted as follows						
	o Clear and reada						
	·	place readily accessible to					
	residents and visi	tors.					
	The facility must	unan aral ar writtan					
	_	upon oral or written rse staffing data available					
	-	eview at a cost not to					
	exceed the comm						
	CXCCCC the contin	idinty oldinadia.					
	The facility must i	maintain the posted daily					
		a for a minimum of 18					
		uired by State law,					
	whichever is grea						
			F00	0356	It is the policy of Garden Villa	to	08/18/2013
	Based on obse	rvation, interview, and			accurately post nurse staffing		
		the facility failed to			information as required.Garder	า	
		t the daily resident			Villa submits the following action		
	, , , , , , , , , , , , , , , , , , ,	,			as evidence of its commitment	to	
		facility's posted staffing			compliance with regulatory		
	data record for	3 of 5 days of the			requirements. I. What corrective	⁄e	

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Event ID: DEFE11

Facility ID: 000007

If continuation sheet Page 5 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING COMPLETED			
		155019	B. WIN	G		07/19/	2013
NAME OF I	PROVIDER OR SUPPLIEI	3	•	STREET .	ADDRESS, CITY, STATE, ZIP CODE	•	
					CURRY PK		
GARDEN	N VILLA - BLOOMIN	NGTON		BLOOM	MINGTON, IN 47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG		d for	DATE
	survey.				action(s) will be accomplished those residents found to have		
					been affected by the deficien		
	Findings include:				practice?The posted census		
					been corrected. II. How other		
		n July 15, 2013 at			residents having the potentia		
		e posted staffing data			be affected by the same defice		
		on the receptionist's			practice will be identified and what corrective action(s) will		
		a total resident census			taken?Census will be verified		
	of 176.				the Admissions coordinator to		
	Observation on July 16, 2013 at 8:30 a.m., the posted staffing data record located on the receptionist's desk				ensure correct postings. III.		
					measures will be put into place		
					what systemic changes will b made to ensure the deficient	е	
					practice does not recur? Car	eful	
	indicated a total	al resident census of			review of daily resident censu		
	181.				posting will be conducted with		
					staffing and Admissions		
	Observation or	n July 17, 2013 at 9:00			coordinators to ensure		
		ed staffing data record			accuracy. IV. How corrective action(s) will be monitored to		
		receptionist's desk			ensure the deficient practice		
		al resident census of			not recur?Administration will		
	176.				audit the staffing data record		
					to posting. Audit results will b		
	Review of the	facility 's resident			presented in Quality Assuran monthly times 3 months.At 3	ce	
		ed by the Administrator			months, Quality Assurance w	rill	
	-	13 at 2:30 p.m.,			review previous audit results		
	1	uly 15, 2013 resident			determine if the audits can be		
		the July 16, 2013			reduced to monthly. Quality		
		is at 183; and the July			Assurance will be looking for		
		ent census at 181.			at least 95% compliant to red to monthly. If not meeting	uce	
	17, 2010 16810	on ochous at 101.			the benchmark weekly audits	will	
	Interview on I	uly 17, 2013 at 10:45			continue. V. August 18, 2013		
		-					
		ctor of Nursing indicated					
	_	sus is posted daily with					
		ffing data record at the					
	front reception	ist 's desk.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	(X3) DATE SURVEY COMPLETED 07/19/2013			
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO	ODE			
GARDEN	I VILLA - BLOOMIN	IGTON	BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DEFE11

Facility ID: 000007

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155019	B. WIN			07/19/	2013
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CURRY PK		
GARDEN	I VILLA - BLOOMIN	GTON			MINGTON, IN 47403		
	I VILLA - BLOOMIN	91011		BLOOM			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000371	483.35(i)						
SS=F	FOOD PROCURI						
		RE/SERVE - SANITARY					
	The facility must -						
		from sources approved or					
	local authorities;	actory by Federal, State or					
		e, distribute and serve food					
	under sanitary co						
	-	rvation, interview, and	F00	0371	It is the policy of Garden Villa	ı to	08/18/2013
		the facility failed to	100	00,1	store , prepare, distribute, and		00/10/2015
	•	hot water for 1 of 1			serve food under sanitary		
	_				conditions.Garden Villa submit	is	
	_	inks, failed to ensure 1			the following action as evidence		
		ezer temperatures			of its commitment to compliance		
		ed at zero degrees or			with regulatory requirements. I		
	below and faile	d to ensure staff			What corrective action(s) will b		
	washed their ha	ands between			accomplished for those resider found to have been affected by		
	residents durin	g meal service as			the deficient practice? a. Mixin	•	
	indicated by fac	cility policy.			valve was replaced on the sink	-	
		- 515			the day observed. Sink/hot wa		
	Findings includ	۵.			available and functioning as		
	i mamgo molad				required. b. Freezer was		
	1 Observation	an July 15, 2012 of			assessed to ensure good work	-	
		on July 15, 2013 at			condition by Lower's Heating a		
		h the Dietary Chef			Cooling. In addition to ensuring	3	
	-	ted no hot water was			the current freezer is in good		
	available at the	kitchen handwashing			working condition a new freeze was ordered to be used in	er.	
	sink.				addition to the current freezer	to	
					reduce stacked products	10	
	Observation on	1 July 16, 2013 at 8:00			and improve air flow to		
		Dietary Chef present,			maintain zero degrees. Until th	ie	
		ot water was available			new freezer is in place the froz		
		nandwashing sink.			food shipments have been		
		_			changed to 2 a week instead of		
		the kitchen were			large order. Therefore reducin		
		washing their hands			the freezer capacity to half. c	-	
	at the observed	d handwashing sink.			Hand washing re-education	atoff	
					conducted with all direct care s	sidii	
			1		and dietary. II. How other		

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Event ID: DEFE11

Facility ID: 000007

If continuation sheet Page 8 of 22

NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BLOOMINGTON (X4) ID SIMMARY STATEMENT OF DEPICTIVENEY GARDEN VILLA - BLOOMINGTON (X5) IS SIMMARY STATEMENT OF DEPICTIVENEY FREEN (BACIT DEPICENCY MINT RE PRECEDED BY PILL) TAG (REQULATORY (No. LED DEPICTIVEN OF PROMATION) On July 15, 2013 at 10:55 a.m.; the Dietary Chef provided a copy of the facility's "Correct Method to Wash Hands" non-dated policy. Review of the policy indicated, "Use a designated sink for handwashing. Wet hands and apply soap. Rub hands vigorously making sure to wash palms, back of hands, between fingers and forearms for at least 20 seconds in water of at least 100 F [degrees Fahrenheit]" 2. Observation on July 15, 2013 at 10:10 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Lee cream into the trash. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. In the cream into the trash. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BLOOMINGTON IVA; ID PREFIX TAG SIMMARY STATIMENT OF DETICENCES (BACH DEPICIONCY MIST BE PRECIDED BY FULL TAG (BACH DEPICION MIST BE PRECIDED BY FULL TAG (BACH MIST BACH MIST BE ALL PROPROMENTS. TAG SEMBLATORY OR WINT BE COMPICED AND THE PRECIDENT BE COMPICED AND THE PRECIDENT BE COMPICED. TAG (BACH MIST BACH MIST BE COMPICED AND THE PRECIDE MIST BE COMPICED. TAG (BACH MIST BACH MIST BACH MIST BE COMPICED. TAG (BACH MIST BACH MIST BA	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	I DING	00	COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BLOOMINGTON (XA) ID SIMMARY STATEMENT OF PERCEDCIB BY FULL TAG On July 15, 2013 at 10:55 a.m.; the Dietary Chef provided a copy of the facility's "Correct Method to Wash Hands" non-dated policy. Review of the policy indicated, "Use a designated sink for handwashing. Wet hands and apply soap. Rub hands vigorously making sure to wash palms, back of hands, between fingers and forearms for at least 20 seconds in water of at least 100 F [degrees Fahrenheit]" 2. Observation on July 15, 2013 at 10:10 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Ice cream stored just inside and to the right of the open side of the walk in freezer was observed to be soft. The walk in freezer was observed to be soft and then discarded the ice cream into the trash. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit.			155019				07/19/	2013	
ANAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BLOOMINGTON IN 47403 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG ON JUly 15, 2013 at 10:55 a.m.; the Dietary Chef provided a copy of the facility's "Correct Method to Wash Hands" non-dated policy. Review of the policy indicated, "Use a designated sink for handwashing. Wet hands and apply soap. Rub hands vigorously making sure to wash palms, back of hands, between fingers and forearms for at least 100 F [degrees Fahrenheit]" 2. Observation on July 15, 2013 at 10:10 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Lec cream stored just inside and to the right of the open side of the walk in freezer was observed to be soft. The walk in freezer was observed to be soft and then discarded the ice cream into the trash. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Lec ream stored just inside and to the right of the open side of the walk in freezer was observed to be soft. The walk in freezer was observed to be full of meats. The Dietary Chef verified the ice cream to be soft and then discarded the ice cream into the trash. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Alterative sink has been identified for hand washing if hid water not available and staff have been educated. Immediate attention for repair will be belien identified for hand washing if hid water not available and staff have been educated. Inmediate attention for repair will be bear identified for hand washing if hid water not available and staff have been educated. Immediate attention for repair will be bear identified and what corrective action(s), will be bear identified and what corrective action(s), will be bear identified				р. W II V		ADDRESS, CITY, STATE, ZIP CODE			
SARDEN VILLA - BLOOMINGTON BLOOMINGTON, IN 47403	NAME OF F	PROVIDER OR SUPPLIE	R						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Or July 15, 2013 at 10:55 a.m.; the Dietary Chef provided a copy of the facility's "Correct Method to Wash Hands" non-dated policy. Review of the policy indicated, "Use a designated sink for handwashing. Wet hands and apply soap. Rub hands vigorously making sure to wash palms, back of hands, between fingers and forearms for at least 20 seconds in water of at least 100 F [degrees Fahrenheit]" 2. Observation on July 15, 2013 at 10:10 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Loe cream into the trash. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Loe cream into the trash.	GARDEN	VILLA - BLOOMII	NGTON						
TAG On July 15, 2013 at 10:55 a.m.; the Dietary Chef provided a copy of the facility's "Correct Method to Wash Hands" non-dated policy. Review of the policy indicated, "Use a designated sink for handwashing. Wet hands and apply soap. Rub hands vigorously making sure to wash palms, back of hands, between fingers and forearms for at least 20 seconds in water of at least 100 F [degrees Fahrenheit]" 2. Observation on July 15, 2013 at 10:10 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside ten cream to be soft. The walk in freezer was observed to be soft. The walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Is considered the walk in freezer thermometer measured the inside temperature at 16 degrees fahrenheit. It is considered the walk in freezer was observed to be soft and then discarded the loe cream into the trash. PREFIX TAG TAG TAG TAG TAG TAG TAG TAG	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN		ISTRUCTION 00	(X3) DATE S	ETED
		155019	B. WING			07/19/	2013
	PROVIDER OR SUPPLIER		1	100 S C	DDRESS, CITY, STATE, ZIP CODE CURRY PK NGTON, IN 47403		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR On July 15, 20' Dietary Chef principle facility's "Critical Food Service" Review of the principle following temporatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing what hazardous food [zero degrees of the principle following temperatures is when dealing when dealing when dealing when degrees of the principle following temperatures is when dealing w	GTON TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 13 at 10:55 a.m.; the rovided a copy of the fall Temperatures for non-dated policy. Policy indicated, "The ferature guidelines, federal Food and Drug for 2009 Food Code fining these for particularly important fith potentially fls Frozen foods 0 F feahrenheit] or below. of RN #1 on July 15, form; indicated lack of for use of sanitizing fiven assisting two fig lunch. RN #1 was fing food for Resident flowed the chair, in flent was seated. RN find Resident #10 with flout washing hands fing gel. dated Handwashing	ST 1 B II PRE	100 S C	CURRY PK	rom the sa a sir c. staff re d hot st nd	(X5) COMPLETION DATE
	Chef on July 19	ovided by the Dietary 9, 2013 at 2:45 p.m. en to Wash Hands ies."			weekly for 3 months to ensure water requirements. Audit result will be reviewed in Quality Assurance committee monthly At 3 months, Quality Assurance will review previous audit result to determine if the audits can be reduced to monthly. Quality Assurance will be looking for	ults e ts	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2013 FORM APPROVED OMB NO. 0938-0391

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	A. BUILDING B. WING		COMPLETED 07/19/2013
PROVIDER OR SUPPLIER		STREET A		
I VILLA - BLOOMIN SUMMARY S' (EACH DEFICIEN		1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK MINGTON, IN 47403 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) at least 95% compliant to redu to monthly. If not meeting the benchmark weekly audits continue. b. Freezer temperat are being monitored twice dai ensure they stay below zero degrees. Care is being taken when staff need to be in the freezer frequently to reduce th door from being open long an reducing the overall temperate Second freezer will be in and ready for use September. Tw deliveries a week are now bei made instead of one large order to reduce the freezer capacity load thus increasing flow and maintaining the temperature at zero or below. 3 months, Quality Assurance review previous audit results to determine if the audits can be reduced to monthly. Quality Assurance will be looking for at least 95% compliant to redu to monthly. If not meeting the benchmark weekly audits continue. c. Hand washing audits will be conducted twice weekly on each unit for 3 mor At 3 months, Quality Assurance will review previous audit result to determine if the audits can reduced to monthly. Quality Assurance will be looking for at least 95% compliant to redu to determine if the audits can reduced to monthly. Quality Assurance will be looking for at least 95% compliant to redu to determine if the audits can reduced to monthly. Quality Assurance will be looking for at least 95% compliant to redu to monthly. If not meeting the benchmark weekly audits continue. V. August 18, 201	will cures ly to he d dure. To ing air At will to he d dure will le he he de dure will le he he dure will le he dure will le he he he dure le he he he dure le he

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DEFE11

Facility ID: 000007

If continuation sheet Page 11 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/19/2013			
GARDEN	ROVIDER OR SUPPLIER I VILLA - BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN 47403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/19/2013	
	PROVIDER OR SUPPLIE	R	1100 S	ADDRESS, CITY, STATE, ZIP CODE S CURRY PK MINGTON, IN 47403	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000431 SS=E	& BIOLOGICALS The facility must services of a lice establishes a system and disposition of sufficient detail to reconciliation; are records are in or all controlled druperiodically reconciliation. Drugs and biologically reconciliation accepted professinclude the appropriate when applied and the facility must biologicals in local proper temperate authorized personal whole accepted profession and the facility must permanently affits storage of controls schedule II of the Abuse Prevention and other drugs when the facility drug distribution quantity stored is dose can be real	employ or obtain the ensed pharmacist who stem of records of receipt of all controlled drugs in o enable an accurate and determines that drug der and that an account of ags is maintained and anciled. gicals used in the facility in accordance with currently sional principles, and opriate accessory and ctions, and the expiration cable. ith State and Federal laws, store all drugs and ked compartments under ure controls, and permit only onnel to have access to the provide separately locked, and compartments for obled drugs listed in the comprehensive Drug on and Control Act of 1976 subject to abuse, except uses single unit package systems in which the siminimal and a missing dily detected.	F000421		00/10/2012
	and interview, ensure staff do	ervation, record review, the facility failed to ocumented the date cations were opened	F000431	It is the policy of Garden Villa label drugs in accordance with current accepted professional principles and discard expired medications per manufacturer	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPL	COMPLETED	
		155019	B. WING			07/19/	2013
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	ER			CURRY PK		
CADDEA	LVIII A DIOOMI	NCTON			IINGTON, IN 47403		
GARDEN	N VILLA - BLOOMI	NGTON		BLOON	IINGTON, IN 47403		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and failed to r	emove outdated			guidelines.Garden Villa submi	ts	
	medications for	or 5 of 10 medication			the following action as evidend		
	carts reviewed				of its commitment to complian		
					with regulatory requirements.		
					What corrective action(s) will be		
	 				accomplished for those reside		
	Findings inclu	de:			found to have been affected by	y	
					the deficient practice?All medication out of date has been	on.	
					discarded. II. How other	511	
	1. Observation	on on July 18, 2013 at			residents having the potential	to	
		h RN # 4 present,			be affected by the same defici		
	•	ottle of over the counter			practice will be identified and	Ont	
					what corrective action(s) will b	е	
	,	lilk of Magnesia) in the 6			taken?All residents have the		
		n cart #1 was identified			potential to be affected. All		
	to be outdated	d. The bottle of			medication carts have been		
	medication wa	as outdated on May			audited for expired or non-labe	eled	
	2013.	•			drugs. III. What measures w		
					be put into place or what syste		
					changes will be made to ensur		
	Ob	- July 40, 2042 - + 2:45			the deficient practice does not		
		on July 18, 2013 at 2:15			recur?Weekly audits will be		
		# 4 present, indicated a			conducted on all medication can		
	bottle of eye c	Irops on unit 6			to ensure proper labeling and no outdated medications are in		
	medication ca	rt #1 was identified to			use. Medication audits will be	1	
	be outdated.	The eye medication			conducted and results present	-ed	
		ened December 12,			in Quality Assurance Committee		
	2012.				monthly. Audits will be done		
	2012.				weekly for 3 months and then		
					reviewed for scheduled		
					change. IV. How corrective		
		on on July 18, 2013 at			action(s) will be monitored to		
	3:00 p.m., with	h LPN # 6 present,			ensure the deficient practice w		
	indicated an o	pened insulin bottle in			not recur? Medication audits w	/ill	
	the 3 South m	edication cart # 2 did			be conducted and results		
		pen date documented			presented in Quality Assurance		
		nor on the box.			Committee monthly. Audits w		
		ioi on the box.			be done weekly for 3 months a then reviewed for scheduled	ai iU	
					change.At 3 months, Quality		
					Change.At 5 months, Quality		

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		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S		
		A. BU	ILDING	00	COMPLI		
		155019	B. WIN			07/19/	2013
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
CVDDEV	I VILLA - BLOOMIN	NGTON			CURRY PK IINGTON, IN 47403		
					IIING TOIN, IIN 47403		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
1110		n July 18, 2013 at 3:00		1.10	Assurance will review previous	3	
		I # 6 present, indicated			audit results to determine if the		
	•	ned insulin bottle in the			audits can be reduced to		
	•	ation cart # 2 was			monthly. Quality Assurance wi	II	
		o be in a box. There			be looking for at least 95% compliant to reduce to monthly	, If	
		g on the bottle to			not meeting the benchmark	,·	
		esident the insulin			weekly audits will continue. V.		
	belonged to.				August 18, 2013		
	_	pen date on the insulin					
		S asked a resident on					
	the 3 south un	it whether he took that					
		lin or not. The asked					
	resident indica	ited he did and LPN #6					
	stated, "I thou	ght so. It's his."					
	3. Observation	n on July 18, 2013 at					
	3:00 p.m., with	LPN # 6 present,					
	indicated an o	pened insulin bottle in					
	the 3 south me	edication cart # 3 was					
	identified to be	outdated. The insulin					
	bottle was ope	ned May 1, 2013.					
		n July 18, 2013 at 3:00					
		I #6 present, indicated					
	•	ned insulin bottle in the					
		ation cart #3 was					
		outdated. The insulin					
	bottle was ope	ned May 31, 2013.					
		n on July 18, 2013 at					
	-	LPN # 14 present,					
		pened insulin bottle in					
	the 2 unit med	ication cart # 4 was					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00		SURVEY LETED 0/2013	
NAME OF I	PROVIDER OR SUPPLIE	R.		T ADDRESS, CITY, STATE, ZIP CODE		
GARDEN	N VILLA - BLOOMIN	NGTON		S CURRY PK DMINGTON, IN 47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	O BE	(X5) COMPLETION DATE
		e outdated. The insulin ened June 8, 2013.				
	regard to unit 2	erview with LPN #14, in 2 medication cart #3, in expires 30 days after tle is opened.				
	10:00 a.m., with indicated an operation of the last indication of the last indication in the last indentified to be	n on July 19, 2013 at th LPN # 7 present, pened over the counter Magnesia) in the 3 on cart # 5 was e outdated. The is outdated March,				
	Guidelines ind use: Vials: Ke refrigeratorT	hrow away an opened ays of use, even if there				
	of "Vials and A Medications" p	y 19, 2013 at 9:35 a.m., Ampules of Injectable policy (non-dated) e Director of Nursing				
		oules of injectable re used in accordance facturer's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155019		ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155019	B. WIN			07/19/	2013
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
GARDEN	I VILLA - BLOOMIN	IGTON			CURRY PK IINGTON, IN 47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ons or the provider					
	use, and dispo	ections for storage, sal.					
	Procedures:						
	provider pharm	mpules sent from the nacy in a box or					
		the label on the outside t box or container.					
	the first person recorded on m	ened and the initials of to use the vial are ultidose vials (on the accessory label affixed e)					
	be used (until the expiration date allowed by state facility policy for the state of the expiration of	n multidose vials may the manufacturer's for the length of time te law/according to or thirty days) if eals no problems during					
	3.1-25 (o)						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/19/2013
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE CURRY PK	
GARDEN	I VILLA - BLOOMIN	NGTON		MINGTON, IN 47403	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE :	SURVEY		
AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER:		A BIIII	a. BUILDING 00			COMPLETED	
		155019	B. WING			07/19/	2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	L			CURRY PK			
CADDEN	IV/III A DI OOMIN	ICTON						
GARDEN	I VILLA - BLOOMIN	IGTON		BLOOK	MINGTON, IN 47403			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F000463	483.70(f)					•		
SS=D	RESIDENT CALL	SYSTEM -						
	ROOMS/TOILET	/BATH						
	The nurses' static	on must be equipped to						
	receive resident of	calls through a						
	communication sy	ystem from resident rooms;						
	and toilet and bat	hing facilities.						
	Based on obse	rvation, interview, and	F00	0463	It is the policy of Garden Villa	to	08/18/2013	
	record review,	the facility failed to			have resident call systems tha			
		ts' call light systems			communicate to staff.Garden	-		
		appropriately for 2 of 40			submits the following action as	3		
	_	• • •			evidence of its commitment to			
		wed for working call			compliance with regulatory			
	light. (Residen	it #71 and #28)			requirements. I. What corrective			
					action(s) will be accomplished	tor		
					those residents found to have			
	Findings includ	le:			been affected by the deficient			
	3. 3.				practice? Resident #71 and resident #28 are roommates a	nd		
					share the same call light syste			
	4 Danidant#7	7415 - 1::-:			The system was functioning at			
		'1's clinical record was			the call light panel indicating w			
	reviewed on Ju	ıly 17, 2013 at 10:30			room needed assistance and t			
	a.m.				alarm was audibly sounding.			
					maintenance department			
					determined the cause of the			
	The current MF	OS (Minimum Data Set			problem to be the bathroom			
		•			switch which had not been			
	,	ated May 4, 2013,			completely re-set after it had			
	indicated a BIM	AS (brief interview for			been answered. This switch w	/as		
	mental status)	score of 10, which			replaced, for easy resetting. II			
	indicated the re	esident was			How other residents having the	Э		
	interviewable.				potential to be affected by the			
					same deficient practice will be			
					identified and what corrective			
	1 1 45 0040				action(s) will be taken? All	L -		
	_	at 11:00 a.m., during			residents have the potential to			
	resident intervi	ew, Resident #71 was			affected. All call lights have be	een		
	asked to push	her call light.			monitored for proper working			
	•	vas observed to push			function. All lights are			
		The hall light indicator			functioning. On-going preventative maintenance was			
	u ie can ngrit. T	ne nan ngin mulcator			preventative maintenance was			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	A. BUILDING 00			COMPLETED	
155019		B. WI			07/19/	2013	
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER	X.			CURRY PK		
	I VILLA - BLOOMIN				IINGTON, IN 47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	being done on a monthly basis		DATE
		unit staff the resident			but this has been changed to	•	
		stance, located outside			weekly. All lights, every room		
		resident's room door			Protocol for a broken light is to		
		. CNA #10 was			notify maintenance for immed		
		t the call light not			attention. This was done each	ו	
	•	tly and she did tell			time a light was identified, however a memo on call light		
		bout this at that time.			maintenance protocol is out for	r all	
		es of maintenance			staff as a reference and		
	_	of the non-working call			re-education. III. What		
	•	nce did come into			measures will be put into place		
	Resident #71's	room and fixed the			what systemic changes will be made to ensure the deficient	•	
	call light.				practice does not recur? Wee	kly	
					preventative maintenance on		
					call lights is being done to ens		
	Continued obs	ervation on July 15,			proper function. Memo is out		
	2013; indicated	that there were no			all staff on call light maintenar		
	staff at the call	light panel. Direct			protocol as a reference. IV. Ho corrective action(s) will be	ow	
	care staff were	observed to be on the			monitored to ensure the defici	ent	
	resident unit ha	all.			practice will not recur?Weekly		
					preventative maintenance on		
					call lights is being done to ens	ure	
	During observa	ation of Resident #71			proper	200	
	_	13 at 9:25 a.m., the			function. Preventative mainte ce will be reviewed in Quality	ııdıı	
	1	and checked the call			Assurance committee monthly	,	
		not light up on the			and reviewed for schedule		
	outside wall.				change. V. August 18, 2013		
	Tatolao maii.						
	2. Resident #2	8's clinical record was					
	reviewed on Ju	ıly 18, 2013 at 10:00					
	a.m.						
	The ourrest Mar	OS (Minimum Data Sat					
		DS (Minimum Data Set lated May 3, 2013,					
I	, (336331116111 <i>)</i>	acou iviay o, 2010,	1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019		LDING	ONSTRUCTION 00	(X3) DATE COMPL 07/19/	ETED
	PROVIDER OR SUPPLIER		p. w.i.	STREET A	ADDRESS, CITY, STATE, ZIP CODE CURRY PK IINGTON, IN 47403	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
		AS (Brief Interview for score of 15, which esident was					
	17, 2013 at 9:3 call light was n #28 was obser light and the ha on. It was report Resident #28's working approprontacted Mair	Resident #28 on July 80 a.m.; indicated the ot working. Resident wed to push the call allway light did not turn orted to CNA #11, call light was not oriately. CNA #11 intenance at that time no observation of xing the light.					
	p.m., with Mair indicated they light checks mo on each unit. room checkup Supervisor pro Material and Laforms indicated "Unit 400. Root to be replaced Get new call ligicall button." an 1. Room 107A room without light	ally 19, 2013 at 2:30 Intenance Supervisor, do routine random call conthly on 4 to 5 rooms They also do yearly s. The Maintenance vided a copy of abor Records. The d dated July 01, 2013, om 18. Call light needs Service Performed: ght button. Replaced d July 18, 2013, "Unit a. Call light bulb outside ghting up." Service ecked light bulb, it was					

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I 155010	BUILDING 00 WING	COMPLETED 07/19/2013
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA - BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CO 1100 S CURRY PK BLOOMINGTON, IN 47403	DE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
good. Had to reset bathroom switch. Everything is fine." The Maintenance Supervisor indicated that is the only call that came in this week for call lights. 3.1-19(u)(1)		

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